FIRST STEPS

Department of Health (DOH)
PO Box 47880
Olympia WA 98504-7880

Department of Social & Health Services (DSHS)
PO Box 45530
Olympia WA 98504-5530

TO: Maternity Support Services/Infant Case Management Providers

FROM: Sherilynn Casey, Manager
Maternal and Infant Health

RE: **Integrated Maternity Support Services/ICM Billing Instructions**

Enclosed is a copy of the integrated Maternity Support Services (MSS)/Infant Case Management (ICM) Billing Instructions, dated October 2003.

Questions about this document may be addressed to:

Diane Bailey, Coordinator, Nurse Consultant	(360) 236-3580
Becky Peters, Behavioral Health Consultant	(360) 236-3532
Judy Oliver, Nutrition Consultant.....	(360) 236-3599
Kathi LLoyd, Health Education Consultant	(360) 236-3552
Diane Tiffany, Infant Case Management Program Manager.....	(360) 725-1655
Lenore Lawrence, First Steps Clearinghouse Program Manager	(360) 725-1666

This is a blank page.

Department of Social and Health Services
Medical Assistance Administration
and
Department of Health
Maternal and Infant Health

Maternity Support Services/ Infant Case Management

Billing Instructions
(WAC 388-533-0300)
October 2003

About this publication

This publication supersedes all previous Maternity Support Services and Maternity Case Management Billing Instructions and the following Numbered Memorandum: 02-28 MAA, 02-29 MAA, 03-01 MAA, and 03-31 MAA.

Published in coordination with Washington State's:

Medical Assistance Administration
Department of Social and Health Services
and
Maternal and Infant Health
Department of Health

October 2003

Table of Contents

Continued on next page…

Table of Contents (cont.)

Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. *[WAC 388-502-0020(2)]*

Provider Questions:

- Regarding provider's change of Coordinator, address, and/or telephone number, call the First Steps Clearinghouse Program Manager at MAA, (360) 725-1666.
- Regarding policy or program oversight and changes in ownership for integrated Maternity Support Services, call DOH, Maternal and Infant Health at (360) 236-3505.
- Regarding policy or program oversight for Infant Case Management (ICM), call the ICM Program Manager at MAA, (360) 725-1655.

Where do I call to ask about a provider application packet?

Call the Department of Health at:
(360) 236-3505

Where do I send my claims?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Electronic billing?
http://maa.dshs.wa.gov/ecs

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's website:
http://maa.dshs.wa.gov
(Click on "Provider Publications/ Fee Schedules")

Where do I call if I have questions regarding…

Payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Where can I download electronic copies of DSHS forms?

http://www.wa.gov/dshs/dshsforms/forms/eforms.html.

This is a blank page.

Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance program. The definitions are presented as a guide for the provider's use. They are not intended to be inclusive, nor are they intended to inhibit professional judgment. The criteria apply to all providers and contractors.

ADATSA/DASA Assessment Centers - ADATSA refers to the Alcohol and Drug Addiction Treatment and Support Act. DASA is the Division of Alcohol and Substance Abuse. Agencies contracted by DASA to provide chemical dependency assessment for ADATSA clients and pregnant women. Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

Advocacy – For the purposes of this program, means actions taken to support the parent(s) in accessing needed services or goods and helping the parent(s) to develop skills to access services.

Applicant – A person who has applied for medical assistance.

Assurances Document – A signed agreement documenting that the provider understands and agrees to maintain certain required program elements; and to work toward integrating other specifically recommended practices. Also referred to as the "MSS/ICM Assurances" document.

Authorization requirement – A condition of coverage and reimbursement for specific services or equipment, when required by WAC or billing instructions.

Basic Health Messages – For the purposes of this program, means preventative health education messages designed to promote healthy pregnancies, healthy newborns, and healthy parenting during the first year of life.

Case Management – For the purposes of this program, means services to assist individuals who are eligible under the Medicaid state plan to gain access to needed medical, social, educational, and other services.

Chemical Dependency – A condition characterized by reliance on psychoactive chemicals. These chemicals include alcohol, marijuana, stimulants such as cocaine and methamphetamine, heroin, and/or other narcotics. Dependency characteristics include: loss of control over the amount and circumstances of use, symptoms of tolerance, physiologic and psychologic withdrawal when use is reduced or discontinued, and substantial impairment or endangerment of health, social and economic function.

Chemical Use - Chemical use means any ingestion of psychoactive chemicals or any pattern of psychoactive chemical use. Use patterns are characterized by continued use despite knowledge of having persistent or reoccurring social, occupational, psychological or physical problems that are caused by or exacerbated by use.

Childbirth Education Classes (CBE) - A series of educational sessions offered in a group setting and led by an approved instructor that prepare pregnant woman and her support person for an upcoming childbirth. A separate SSPS billing number is required to be a provider of these services. See MAA's separate Childbirth Education Billing Instructions.

Childcare -

DASA – (Division of Alcohol and Substance Abuse) means the childcare for women attending DASA-funded outpatient alcohol or drug treatment services that may be provided through the treatment facility.

First Steps - Childcare funded through the First Steps Program for the care of children of pregnant or postpregnant women who are attending appointments for Medicaid-covered services, pregnant women on physician ordered bed rest and for visits to the NICU after delivery.

Child Protective Services (CPS) - The program within the Division of Child and Family Services authorized by statute (RCW 26.44) to receive and investigate referrals of child abuse, neglect, and exploitation.

Children's Coordinated Services (CCS) - The federal Title V program for children with special health care needs.

Children's Health Program - A state-funded full-scope health program for children 17 years of age and younger who are not eligible for a federal health program

Children with Special Health Care Needs (CSHCN) - Title V (federally funded) program for children with special health care needs.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Clinical Supervision – A formal process of professional support and learning that enables an individual to develop additional knowledge and competence in their professional discipline. Clinical supervision focuses on matters related to client safety and best practice for the identified professional discipline. Clinical supervision must be provided by someone from the same discipline with more experience and education.

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Community and Family Health (CFH) - The division within the state Department of Health whose mission is to improve the health and well-being of Washington residents, with a special focus on infants, children, youth, pregnant woman, and prospective parents.

Community Services Office (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level.

Consultation – For purposes of this program, means the practice of conferring with other professionals to share knowledge and problem-solve with the intent of providing the best possible care to clients.

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs.

Core Services – For the purposes of this program, means the services that provide the framework for interdisciplinary, client-centered Maternity Support Services and Infant Case Management. These services include: Client Risk Screening, Basic Health Messages, Basic Linkages, and Minimum Interventions.

DASA - See ADATSA

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Department of Health (DOH) – The agency whose mission is to protect and improve the health of people in Washington State.

~~**Doula** (Labor Support) - A supportive companion trained and certified to provide physical, emotional, and informational support to women (and their partners) during labor, birth, and postpartum.~~

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – Means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid. [WAC 388-500-0005]

EPSDT Provider - (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as a EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, optometrist or ophthalmologist who is an enrolled Medical Assistance provider and performs all or one component of the ESPDT screening.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Federal Aid - Matching funds from the federal government received by the state for medical assistance programs.

First Steps - The 1989 Maternity Care Access Act, known as First Steps. This program provides maternity care for pregnant and post-pregnant women and health care for infants. The program is administered jointly by DSHS and DOH. First Steps maternity care consists of obstetrical care, case management, and support services such as community health nursing, nutrition, psychosocial visits, and childbirth education classes. Ancillary services include expedited eligibility determination, case finding, outreach, childcare, and transportation. Specialized substance abuse treatment services, offered through the Omnibus Drug Act, encompass residential and outpatient treatment and transitional housing.

First Steps Childcare – See "Childcare."

First Steps Consultation Team - The state team consisting of both DSHS and DOH managers plus state staff representing infant case management, the First Steps Clearinghouse, and members of the interdisciplinary team: community health nurse, behavioral health specialist, nutritionist, and health educator. The First Steps Consultation team provides technical assistance to programs and professional disciplines; develops protocols and guidelines for service delivery; monitors

(see next page for rest of definition)

data related to service delivery and program outcomes; and make site visits to Integrated MSS/ICM agencies for monitoring purposes.

Home visit – For the purposes of this program, means services delivered in the client's place of residence or other setting (as in the hospital), if the Maternity Support Services/Infant Case Management provider is not located on the hospital campus. If a visit is not possible, due to an unsafe place of residence or a potential problem with client confidentiality, an alternative site may be billed as a home visit. **NOTE**: The reason for using an alternate site for visitation [instead of the home] must be documented in the client's record.

Infant Case Management (ICM) – A program that provides enhanced case management service to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle and up to the baby's first birthday.

Interagency Agreement – A written letter of agreement between two agencies for the exchange of referrals or service provision (e.g., a written agreement in letter format that agrees to an exchange of referrals or services for MSS/ICM clients).

Interdisciplinary Team – Members from different professions and occupations that work closely together and communicate frequently to optimize care for the client (pregnant women and infant). Each team member contributes their knowledge, skill set, and experience to support and augment the contributions of their team members.

Linkages – Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.

Local match - Nonfederal funds provided by local entities to match the federal Title XIX funds provided for a given program.

Managed care – A comprehensive system of medical and health care delivery including preventive, primary specialty, and ancillary health services. These services are provided through a managed care organization (MCO) or primary care case management (PCCM) provider. [WAC 388-538-050]

Maternal and Infant Health (MIH) - A section within the state Department of Health. MIH works collaboratively with DSHS to provide clinical consultation, oversight and monitoring of the Integrated Maternity Support Services / Infant Case Management program.

Maternity Support Services (MSS) – Preventative health services for pregnant/postpregant-women including: professional observation, assessment, education, intervention, and counseling. The services are provided by an interdisciplinary team consisting of at minimum, a community health nurse, a nutritionist, and a behavioral health specialist. Optional members of the team are community health workers working under the direction of a professional member of the team ~~and doulas~~.

Maternity cycle – Eligibility period for Maternity Support Services which begins during pregnancy and continues to the end of the month in which the 60 days post pregnancy occurs.

Maximum allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program;
- Medically needy program

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state Children's Health Insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification Card – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly "course of treatment" available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Minimum interventions – Defined levels of client assessment, education, intervention and outcome evaluation for specific risk factors found in client screening for MSS/ICM services, or identified during ongoing services.

Office Visit – Services are delivered in an office (or an alternate formal) setting at the agency or one of it's off-campus sites (for example: WIC clinic, satellite office, clinic site, mobile office.).

Patient Identification Code (PIC) - An alphanumeric code assigned to each MAA client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Performance measure - An indicator used to measure the results of a focused intervention or initiative.

Postpregnancy period – The two months following a live birth, miscarriage, fetal death, or pregnancy termination.

Provider – Any person or organization that has a signed contract or Core Provider Agreement with DSHS to provide services to eligible clients.

Provider number – An identification number issued to providers who have a signed contract(s) with MAA.

Psychoactive chemicals - Chemicals, including alcoholic beverages, controlled substances, prescription drugs, and over-the-counter (OTC) drugs, which affect mood and/or behavior. Nicotine and food are not considered psychoactive chemicals.

Remittance and Status Report – A report produced by the Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws [http://wsl.leg.wa.gov/wsladm/rcw.htm].

Risk factors – Biopsychosocial factors that could lead to negative pregnancy or parenting outcomes. The MSS/ICM program design identifies specific risk factors and corresponding minimum interventions.

Service plan – The written plan of care that must be developed and maintained throughout the eligibility period for each client in the Maternity Support Services and Infant Case Management programs.

Staff – For the purposes of this program, means the personnel employed by MSS/ICM providers.

Subcontractor - An individual or agency who has contracted with a primary MSS provider to provide services to MSS clients. This individual or agency must be informed of, and comply with, all regulations contained in the Core Provider Agreement and in the Assurances document as they pertain to service delivery to the MSS client. (These include the MSS Billing Instructions.)

Substance abuse – See Chemical Use

Supervision – A process that involves both monitoring and teaching. Supervision should begin prior to intervention and documented as to date, subject matter, follow-up plan, and parties involved.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Unit of service – Fifteen minutes of one-to-one service delivered face-to-face.

Usual and customary charge – The fee that the provider typically charges the general public for the product or service. [WAC 388-500-0005]

Washington Administrative Code (WAC) Codified rules of the state of Washington. [http://www.mrsc.org/wac.htm]

WIC (Women, Infant, and Children) - A special supplemental nutrition program for women, infants, and children.

About the Program

What is the purpose of the integrated Maternity Support Services/Infant Case Management program?

The purpose of the integrated Maternity Support Services (MSS)/Infant Case Management (ICM) program is to provide enhanced support services to eligible pregnant women through the maternity cycle and for eligible families through the month of the infant's first birthday. The purpose of the enhanced services is to improve birth outcomes and respond to clients' individual risks and needs.

This program is collaboratively managed by the Department of Health and the Department of Social and Health Services (DSHS) Medical Assistance Administration.

Program Design

The program is designed to provide interventions as early in a pregnancy as possible in an effort to promote a healthy pregnancy and positive birth and parenting outcomes. Measures of improvement in pregnancy and parenting outcomes include:

- Increased early access and ongoing utilization of prenatal and newborn care;
- A decrease in low birth weight babies; and
- A decline in Infant Mortality Rates.

Additional Goals of Program

Additional goals of the program are:

- To decrease health disparities;
- Reduce the number of unintended pregnancies;
- Reduce the number of repeat pregnancies within two years of deliver;
- Increase the initiation and duration of breastfeeding;
- Reduce tobacco use during pregnancy and pediatric exposure to second-hand smoke;
- Reduce the incidence of SIDS; and
- Increase self-sufficiency of the mother and family unit.

Freedom of Choice/Consent for Services

MSS/ICM clients have the right to choose their MSS/ICM provider, and (if not enrolled in a managed care plan), any other MAA provider, as allowed under Section 1902(a)(23) of the Social Security Act.

1. **Option to Receive Services**
   Any pregnant Medicaid client has the *option* to receive MSS but *cannot be forced* to receive MSS/ICM services that the parent(s) and/or their infant might be eligible (Social Security Act - Section 1915(g)(1)).

2. **Free Choice of Maternity Support Services/Infant Case Management Providers**
   Clients (fee-for-service and managed care) have free choice of which state approved agency they receive MSS/ICM. **You may not limit the client to providers in a given county or clinic, even if the client receives all other MAA-covered services through that county or clinic**.

3. **Free Choice of Other Providers**
   Clients must have free choice of providers of other medical care. Client's enrolled in a managed care plan must use a provider in the managed care plans network for medical care.

Consent/Refusal: Document the client's consent or refusal to receive MSS/ICM services in the client's record.

Other Programs Available

Childbirth Education Classes

Childbirth education classes are a service that can be offered to all Medicaid eligible women. Instruction is in a group setting and may be completed over several sessions. Childbirth education is intended to help the client and her support person(s) to understand the changes the client is experiencing, what to anticipate prior to and during labor and delivery, and to help develop positive parenting skills. Refer to the Childbirth Education Billing Instructions, dated October 2003. The Childbirth Education Consultant can be reached by calling (360) 236-3552.

First Steps Childcare [Refer to WAC 388-533-1000]

A client may be screened and receive authorization for First Steps Childcare for a client's child(ren) during the client's pregnancy or postpregnancy period when the client pursues any of the following covered services for herself or her newborn child(ren):

- Childbirth education classes;
- Delivery/birth (during the mother's hospitalization);
- Dental care;
- Hospital procedures;
- Laboratory tests;
- Infant Case Management (ICM) visits;
- Maternity Support Services (MSS) visits, including nursing, behavioral health, nutrition, and Community Health worker visits; and
- Medical visits.

MAA approval is required for First Steps Childcare for bedrest and when visiting a hospitalized newborn. Unlicensed childcare providers must obtain a DSHS background check before MAA will make payment for childcare. Background checks must be completed prior to the provision of childcare.

For further information on the First Steps Childcare program, MSS/ICM providers should become familiar with the DSHS First Steps Childcare Billing Instructions. To obtain a billing form or to view and/or download a copy of the First Steps Childcare Billing Instructions, go to: http://maa.dshs.wa.gov (click on "Provider Publications/Fee Schedules," and go to First Steps Childcare Billing Instructions.

First Steps Childcare state staff can be reached by calling: 1-888-889-7514.

This is a blank page.

Maternity Support Services

What are integrated Maternity Support Services?

Integrated Maternity Support Services are the merging of Maternity Case Management (MCM) activities into Maternity Support Services during the maternity cycle. Under this integrated program, case management activities are not reimbursed separately.

Integrated Maternity Support Services are provided by a member of the agency's interdisciplinary team: Community Health Nurse, Nutritionist, Behavioral Health Specialist or by a Community Health Worker (acting under the direction of a professional on the Interdisciplinary team). Refer to your Provider Application Packet for detailed information regarding staffing qualifications.

The primary focus of integrated Maternity Support Services is health education assessment, interventions, brief counseling, linkages and referrals given available resources. Professional interventions are based on risk factors that are known to impact pregnancy and parenting outcomes (including Family Planning Performance Measure and the Tobacco Performance Measure).

At the end of the maternity cycle, MSS staff will reassess family needs as they relate to the infant. Families meeting the criteria for Infant Case Management (ICM) will be offered services that focus on client advocacy, linkages and referrals. For those families who did not receive integrated MSS, the MSS/ICM agency may assess whether the client meets the criteria for ICM and offer services as needed.

What are the provider requirements for integrated MSS?

Services under the integrated MSS/ICM program must be provided only by approved MSS providers. Representatives from the Department of Health and the Department of Social and Health Services Medical Assistance Administration recruit and approve providers using the following criteria:

- Services must be delivered in an area of geographic need as determined by DOH/DSHS program guidelines;

- Providers must:

  - ✓ Deliver both integrated MSS and ICM services;
  - ✓ Provide services in both office and home visit settings; and
  - ✓ Assure maintenance of staffing requirements and delivery of service according to program design as outlined in the Provider Application Packet.

  MAA considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment during a Medicaid Audit.

- MSS providers must also:

  - ✓ Refer a client who may need chemical dependency assessment to a provider who is contracted with the Division of Alcohol and Substance Abuse (DASA); and
  - ✓ Screen for the eligible woman's need for childcare, discuss and encourage a safe and healthy child care plan, and authorize the childcare. (See page A.3)

To be reimbursed by MAA for integrated MSS, a provider must:

- Meet the requirements in chapter 388-502 WAC,Provider rules;
- Have a completed, approved MSS/ICM Assurances document, signed by an office or employee qualified to sign on behalf of the provider, on file with MAA;
- Meet the DOH/MAA requirements for a qualified MSS interdisciplinary team as described in the Assurance document;
- Ensure the staff meet the minimum qualifications for the MSS roles they perform;
- Comply with the clinical supervision/clinical consultation guidelines as required in the Assurances document (included in Provider Application Packet);
- Notify the appropriate state discipline-specific consultant when a staff person joins or leaves a designated position;
- Ensure that all newly hired staff receive a First Steps Orientation as soon as possible, but not later than 60 days from the hire date;
- Allow time for required case conferencing activities; and
- Submit billings as instructed in this manual.

Who is eligible for integrated MSS?

To be eligible for integrated MSS, a client must:

- Be pregnant or within 60 days postpregnancy; and
- Present a DSHS Medical Identification (ID) card with one of the following identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP **Children's Health**	Categorically Needy Program - Children's Health
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program- Emergency Medical Only

☞ **Note:** If the client is pregnant but her card does not list one of the above medical program identifiers, please refer her to the local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope maternity care.

Are clients enrolled in an MAA managed care plan eligible for integrated MSS?

Yes! Clients who are enrolled in an MAA managed care plan are eligible for MSS outside their plan. MAA reimburses for integrated MSS/ICM through its fee-for-service system. Coverage and billing guidelines found in these billing instructions apply to managed care clients. **Bill MAA directly.** Clients who are enrolled in an MAA managed care plan will have an "HMO" identifier in the HMO column on their DSHS Medical ID cards.

How long is a client eligible for integrated MSS?

Eligible clients may receive integrated MSS during pregnancy and through the postpregnancy period (the last day of the month from the 60th day after the pregnancy ends). Services will be offered during the maternity cycle as long as there is a demonstrated need based on the core services and minimal interventions. Refer to your Provider Application Packet for detailed information on Core Services.

What is covered for integrated MSS?

MAA covers the following services for integrated MSS:

- Community health nursing visits;
- Nutrition visits;
- Behavioral health visits; and
- Community health worker visits. ~~and~~
- ~~Doula visits.~~*

  * Effective for claims with dates of service on and after April 1, 2004, MAA will no longer reimburse providers for Doula services.

MAA will reimburse MSS providers on a fee-for-service basis for the above services only when the services are:

- Documented in the client's record;
- Provided in a face-to-face encounter;
- Delivered by a qualified staff person acting within their area of expertise; and
- Only when used for the purposes of the integrated MSS program to:

  - ✓ Provide risk screening (see page B.7);
  - ✓ Deliver basic health messages;
  - ✓ Provide interventions based on identified risk factors;
  - ✓ Provide referral and linkages to other services; or
  - ✓ Provide family planning screening.

Determining where integrated MSS services are delivered

The provider, in collaboration with the client, determines whether the services are to be delivered in the home or in the agency. A home visit may be billed for services provided at the client's place of residence, or in the hospital if the MSS agency in not co-located on the hospital campus. If a home visit is not possible, such as in the case of an unsafe place of residence or a potential problem with client confidentiality, an alternate site other than a hospital or a home may be used and billed as a home visit. The reason for using an alternate site of visitation **must** be documented in the client's record.

MSS Performance Measures

Unintended Pregnancy Family Planning Performance Measure

MSS/ICM providers include in their interventions a focus on family planning education so each woman can decide if she wishes to use birth control and which method would work the best for her. Family planning education may be provided throughout the maternity cycle but the completion of the performance measure documentation sheet below is completed in the postpregnancy period.

MSS agencies must include Question 4 from the Family Planning Interview Guide in client's record and, upon request, report the information to the state program for data collection. The complete Family Planning Interview Guide is available on-line at:
http://maa.dshs.wa.gov/firststeps

WITHIN THE 60 DAY POST PREGNANCY PERIOD

MSS/ICM Unintended Pregnancy Performance Measure:

		Yes	No
4a.	Pregnancy planning has been discussed with the client.	•	•
4b.	Client has initiated contraceptive method.	•	•

If yes, check all contraceptive methods that apply:

- Implant
- Injectable
- IUD
- Female Sterilization
- Oral Contraceptives
- Emergency Contraception
- The Patch
- Other – List: _____

- Condom (male)
- Condom (female)
- Diaphragm
- Cervical Cap
- Spermicides
- Vaginal Ring

- Male Sterilization
- Breastfeeding
- Withdrawal
- Abstinence
- Natural Family Planning

Tobacco Cessation Performance Measure

Effective for dates of service on and after July 1, 2004, all MSS/ICM agencies implemented the MSS Tobacco Cessation During Pregnancy Performance Measure.

- Agencies must document in the client's record when each of the six steps listed in the MSS Tobacco Cessation Performance Measure Sheet are addressed and upon request be able to report this information to the state program for data collection. (See page B. 13. for the Tobacco Cessation Performance Measure procedure code.)

- MSS/ICM providers must assure that each and every client is asked about tobacco usage and secondhand smoke exposure and is offered an appropriate and individualized intervention.

MSS Tobacco Cessation Performance Measure

1) Client was asked about tobacco use:
☐ Yes ☐ No

_____ initial _____ date

2) Client advised to quit and assistance offered:
☐ Yes ☐ No ☐ Non-tobacco user

_____ initial _____ date

3) Client was asked about secondhand smoke exposure:
☐ Yes ☐ No

_____ initial _____ date

4) Client advised to eliminate secondhand smoke and assistance offered:
☐ Yes ☐ No ☐ Second-hand smoke not an issue

_____ initial _____ date-

5) Discharge plan addresses tobacco use/exposure and community resources:
☐ Yes ☐ No ☐ N/A - No tobacco use or second-hand exposure

_____ initial _____ date

6) Client progress/outcomes documented in chart:
☐ Yes ☐ No ☐ Intake only - No tobacco use or second-hand smoke

_____ initial _____ date

Maternity Support Services Client Screening Tool

MSS/ICM providers must use the MSS Client Screening Tool [DSHS 13-723 form] with new clients. The screening tool is to be completed by the client, although staff may assist when needed. The form is intended to assist in establishing services that are client-centered. The form must be kept in the client's record.

See **next page** for a sample. To obtain a downloadable copy of the form, go to: http://www.wa.gov/dshs/dshsforms/forms/eforms.html.

To download an electronic copy of the Maternity Support Services (MSS) Client Screening Tool, DSHS 13-723 go to:
http://www1.dshs.wa.gov/dshsforms/forms/eforms.html

Back of Maternity Support Services (MSS) Client Screening Tool, DSHS 13-723

See http://www1.dshs.wa.gov/dshsforms/forms/eforms.html

Billing for Integrated MSS

- **Bill MAA using the mother's Patient Identification Code (PIC) found on the DSHS Medical Identification Card.**

- MSS providers must have an individual face-to-face contact with the pregnant/post pregnancy client before billing any of the integrated MSS/ICM services in the fee schedule, **except** for the following Performance Measures. Neither performance measure is included in the maximum of 60 units that may be billed per maternity cycle. The performance measures are billable only if the required client information has been collected and documented in the client's medical record:
  - √ The Family Planning Performance Measure (procedure code T1023 with modifier HD); and
  - √ The Tobacco Cessation Performance Measure (procedure code S9075 with modifier HD).

- An initial face-to-face visit may be billed to MAA without a signed consent form if the client refuses further services, as long as this refusal is documented in the chart. Only services provided to the pregnant/post-pregnancy woman may be billed.

- Travel, charting, and phone calls are included in the reimbursement of each MSS procedure code.

- Community health nursing visits, nutrition visits, behavioral health visits, and community health worker visits are subject to the following ***limitations*** <u>per client</u>:

- One **unit** equals **15 minutes**

  - ✓ A minimum of 2 units must be provided per day for billed home visits;
  - ✓ A maximum of 6 units may be billed per day for any combination of office and/or home visits; and
  - ✓ A maximum of 60 units from all disciplines combined may be billed for office and/or home visits over the maternity cycle (pregnancy through two months post-pregnancy).

- If the mother becomes pregnant again within 12 months from the previous pregnancy, enter the new "Due Date" in field 19 on the HCFA-1500 claim form for new MSS services. This "resets" the claims processing clock for the new pregnancy.

Fee Schedule for Integrated Maternity Support Services

Use the most appropriate diagnosis code (such as V22.2) when billing for the following procedure codes:

Procedure Code/ Modifier	HCPCS Description	Service	July 1, 2004 Maximum Allowable	
			Office Visit	Home Visit
T1002 HD	RN services, up to 15 minutes **1 unit = 15 minutes**	MSS Community Health Nursing Visit	$30.00	$40.00
S9470 HD	Nutritional Counseling, dietician visit **1 unit = 15 minutes**	MSS Nutrition Visit	$30.00	$40.00
96152 HD	Intervene hlth/behave, indiv **1 unit = 15 minutes**	Psychosocial Visit	$30.00	$40.00
T1019 HD	Personal Care Services, per 15 minutes (Community Health Worker) **Not in a hospital** **1 unit = 15 minutes**	Community Health Worker Visit	$15.00	$20.00
~~S5125 HD~~	~~Attendant Care Services, per 15 minutes [Doula]~~ ~~**1 unit = 15 minutes**~~ *	~~N/A~~	~~$9.00~~	~~$15.00 (home or hospital visits)~~

* Effective for claims with dates of service on and after April 1, 2004, MAA will no longer reimburse providers for Doula services

Fee Schedule for Family Planning Performance Measure

MSS providers must include in their interventions a focus on family planning education so each woman can decide if she wishes to use birth control, and which method would work the best for her.

MSS providers may bill the family planning performance measure procedure if the family planning information has been collected by the end of the maternity cycle and documented in the client's medical record. This procedure code may be billed **only once per client**, per pregnancy.

Use the most appropriate diagnosis code (such as V22.2), when billing for the following procedure code:

Procedure Code/ Modifier	HCPCS Description	Service	July 1, 2004 Maximum Allowable
T1023 HD	Screening to determine appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Family Planning Performance Measure	$10.00

Fee Schedule for Tobacco Cessation Performance Measure

MSS providers **must** ensure that each client is asked about tobacco usage and secondhand smoke exposure and is offered an appropriate and individualized intervention.

MSS providers may bill the tobacco cessation performance measure if the required client information has been collected by the end of the maternity cycle and documented in the client's medical record. (Please see page B.7.) This procedure code may be billed **only once per client, per pregnancy**.

Use the most appropriate diagnosis code (such as V22.2) when billing for the following procedure code:

Procedure Code/ Modifier	HCPCS Description	Service	July 1, 2004 Maximum Allowable
S9075 HD	Smoking Cessation Treatment	MSS Tobacco Cessation Performance Measure	$10.00
Not payable for claims with date of service prior to July 1, 2004			

This is a blank page.

Infant Case Management

What is Infant Case Management (ICM)?

The Infant Case Management (ICM) program is the part of MSS/ICM services that serves high-risk infants and their families. The goal of ICM is to improve the parent(s) self-sufficiency in gaining access to needed medical, social, educational, and other services (SSA 1915[g]).

What are the provider requirements for ICM?

Services under this program are provided only by approved MSS/ICM providers. Representatives from the Department of Health and the Department of Social and Health Services Medical Assistance Administration recruit and approve providers using the following criteria:

- Services must be delivered in an area of geographic need as determined by DOH/DSHS program guidelines;

- Providers must:

  - ✓ Deliver both MSS and ICM services;
  - ✓ Provide services in both office and home visit settings; and
  - ✓ Assure maintenance of staffing requirements and delivery of service according to program design as outlined in the Provider Application Packet.

MAA considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment during a Medical Audit.

To be reimbursed by MAA for ICM, a provider must:

- Meet the requirements in chapter 388-502 WAC, Administration of Medical Program – Provider rules;
- Have a completed, approved MSS/ICM Assurances document, signed by a provider or employee qualified to sign on behalf of the provider, on file with MAA;
- Ensure the staff meet the minimum qualifications for the ICM roles they perform;
- Comply with the clinical supervision/clinical consultation guidelines as required in the Assurances document (included in Provider Application Packet);
- Notify the MAA ICM program manager when there is a staff change in a designated position;
- Ensure that all newly hired staff receive an orientation to First Steps as soon as possible, but not later than 60 days from the hire date; and
- Submit billings as instructed in this manual.

Who is eligible for ICM?

To be eligible for ICM, the mother/infant must:

- Present the infant's DSHS Medical Identification (ID) card with one of the following identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP Children's Health	Categorically Needy Program - Children's Health
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program- Emergency Medical Only

- Need assistance in accessing/providing care for themselves or their family; and
- Meet at least one of the criteria listed on the ICM Intake form [DSHS 13-658]. See **next page**. To obtain a copy of a downloadable form, go to: http://www.wa.gov/dshs/dshsforms/forms/eforms.html

To download an electronic copy of the Infant Case Management (ICM) Intake form, DSHS 13-658 go to:
http://www1.dshs.wa.gov/dshsforms/forms/eforms.html

Are clients enrolled in an MAA managed care plan eligible for ICM?

Yes! Clients who are enrolled in an MAA managed care plan are eligible for ICM outside their plan. MAA reimburses for MSS/ICM through its fee-for-service system. Coverage and billing guidelines found in these billing instructions apply to managed care clients. **Bill MAA directly.** Clients who are enrolled in an MAA managed care plan will have an "HMO" identifier in the HMO column on their DSHS Medical ID cards.

How long is a client eligible for ICM?

Services may continue until the end of the month in which the infant's first birthday occurs. This applies to eligible families who demonstrate a need for assistance in accessing/providing care for the mother and infant and there is an active service plan.

What if the woman becomes pregnant while receiving ICM?

If a woman becomes pregnant again while receiving ICM, ICM services are closed. Begin Maternity Support Services for the new pregnancy and bill using MSS procedure codes. See page E.2, field 19 for HCFA-1500 claim form instructions.

What if the infant is eligible for ICM and placed outside the home?

If an infant is placed outside of the home while receiving ICM, the agency must terminate or deactivate services. If the infant is returned to a parent's home before his/her first birthday, the MSS/ICM agency may rescreen the family for ICM eligibility.

What services are covered under ICM?

MAA reimburses approved providers on a fee-for-service basis for case management under the ICM program including:

- Assessing risk and need;
- Reviewing and updating the infant and parent(s) service plan;
- Referring and linking the client to other agencies; and
- Advocating for the client with other agencies.

The case management activities listed above are covered under the ICM program only when:

- Documented in the client's record;
- Performed by a qualified staff person acting within his or her area of expertise; and
- Used according to program design as described in the MSS/ICM Assurances (included in Provider Application Packet).

Billing for ICM

Bill MAA for ICM services using the baby's Patient Identification Code as listed on the baby's DSHS Medical ID card. Do not use the mother's PIC.

ICM is considered family-based intervention. Therefore, the infant [and family] are only allowed one Title XIX Targeted Case Manager at a time.

The most common examples of duplicate services include nursing intervention services for families at risk for child abuse and neglect through a state contract between DSHS, Children's Administration, Child Protective Services (CPS) and local health jurisdictions; Children with Special Health Care Needs; and HIV/AIDS.

Travel expenses, charting time/documentation, phone calls and mileage are included in the reimbursement rate for ICM.

ICM is provided for mother/newborn meeting eligibility criteria. (Services can be provided from the end of the maternity cycle to the newborn's first birthday.) The following *limitations* per client apply:

One unit equals 15 minutes

- A maximum of 6 units may be billed per month; and
- A maximum of 40 units may be billed during the 10 months following the maternity cycle.

What if the client becomes pregnant again before ICM ends?

Enter the new "Due Date" in field 19 on the HCFA-1500 claim form. This "resets" the claims processing clock for the new pregnancy. All future visits/billing will be for the new pregnancy using MSS procedure codes. You may no longer bill under the Infant's PIC number or for ICM codes

How do you bill for ICM if there was a multiple birth?

ICM is billed using one of the infants' PIC numbers. ICM is a family service and must not be billed for each individual infant.

Fee Schedule for ICM

Effective for dates of service on and after October 1, 2003:

Procedure Code/ Modifier	Diagnosis Code	HCPCS Description	All Settings Maximum Allowable
T1017 HD	V20.1	Targeted Case Management, each 15 minutes 1 unit = 15 minutes	$ 25.00

Billing

What is the time limit for billing?

[Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

Note:	If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

1 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

2 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee must I bill MAA?

Bill MAA your usual and customary fee.

What records must be kept?

[Refer to WAC 388-502-0020]

Providers must:

Make charts and records available to DSHS, its contractors [such as the Department of Health], and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

Specific to Maternity Support Services/ICM:

- When there is more than one provider serving a client or if the provider has subcontractors, a central file containing all information on the client related to MSS/ICM must be kept by the primary MSS/ICM agency.

- Providers must keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth [record PIC, see definition on page 5];
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Place of service.

- Providers must assure that the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains authenticates charts.

- Written documentation in the client's file is required that addresses all areas listed under *Freedom of Choice/Consent* and *Confidentiality and Release of Information* (see page A.2).

- Copy of the following:

  - ✓ Infant Case Management (ICM) Intake form [DSHS 13-658], if appropriate.
  - ✓ Integrated MSS Risk Factor Screening Tool [DSHS 13-723];
  - ✓ Family Planning Performance Measure; and
  - ✓ Tobacco Cessation Performance Measure.

Release of client information must be signed by the client and renewed every 90 days. RCW 70.02

Note: During the transition period, standardized charting forms are being developed which all providers are expected to implement. The first of the forms being piloted is the MSS Risk Factor Screening Tool [DSHS 13-723] (see page B.7). A separate packet related to documentation and charting is under development. During the transition period, agencies can continue to use current forms along with the screening tool. Any documentation format must relate to the provision of the services described in the Provider Application Packet under Core Services and be able to substantiate services being billed and their impact on the client's needs/concerns described in the Service Plan.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, faxed, or laser printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded.**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's DSHS Medical ID card. **Use the mother's PIC for MSS services. Use the baby's PIC for ICM services.** The PIC consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

19. **Reserved for Local Use** – Enter the estimated due date for clients who become pregnant again before ICM ends. This is necessary in order to "Reset" the clock for the new pregnancy in the claims system.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) **Print in field 19 "SEE BOX 22."**

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403).

Do not use slashes, dashes or hyphens to separate month, day year.

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
11	Office
12	Client's residence (home visit)
21	Inpatient Hospital
99	Other

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code and modifier from these billing instructions.

24E. **Diagnosis Code**: Required. Enter the appropriate diagnosis codes.

24F. **$Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. One date of service per billed line. Multiple units will be billed regularly using the 15-minute codes.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. Enter the name of private insurance company in 9D. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use a dollar sign or decimal point or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, MSS provider, etc.). When a valid group number is entered in this field, payment will be made under this number.
Enter the MSS provider number assigned to you by the Medical Assistance Administration when you signed your Core Provider Agreement. This is a seven-digit provider number that appears on the Remittance and Status report received with reimbursement for services. Please use this number in field 33.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Integrated Maternity Support Services

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ( ) (Medicare #) MEDICAID (X) (Medicaid #) CHAMPUS ( ) (Sponsor's SSN) CHAMPVA ( ) (VA File #) GROUP HEALTH PLAN ( ) (SSN or ID) FECA BLK LUNG ( ) (SSN) OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070160SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH MARY J

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 60 SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 600 CENTRAL STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ( ) Married ( ) Other ( )

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: EDD 05/31/04 "NEW DUE DATE"

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.2
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		T1002	HD	V22.2	5000	2				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN ( )

26. PATIENT'S ACCOUNT NO.: SMITH

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )

28. $ TOTAL CHARGE: 5000

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 5000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

MSS PROVIDER A
1500 MADISON
ANYTOWN WA 98000

PIN# GRP# 7234567

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Infant Case Management

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): JP060103SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH JOEY P

3. PATIENT'S BIRTH DATE MM DD YY: 06 01 03 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 600 CENTRAL STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.1
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12	01	03	12	01	03	11		T1017	HD	V20.1	7500	3				
2																
3																
4																
5																
6																

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: SMITHBABY

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 7500

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 7500

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

MSS PROVIDER A
1500 MADISON
ANYTOWN WA 98000

PIN# GRP# 7234567

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500